

REPORTABLE CONDITIONS

[KRS 214.010](#)⁽⁵⁾ and [902 KAR 2:020](#)⁽⁶⁾ require health professionals to report suspected communicable disease conditions to the local health department servicing the jurisdiction in which the person suspected of disease resides or to the Kentucky Department for Public Health (KDPH). Prompt reporting of a suspected communicable disease permits health officials to exercise the appropriate measures to prevent the spread of disease.⁽⁷⁾ ([Exhibit 5A](#))



Kentucky Reportable Disease Form
Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS1E-C
Frankfort, KY 40621-0001

Disease Name _____

Mail Form to Local Health Department

| DEMOGRAPHIC DATA | | | | | | |
|--|-----------------------|--|--|---|---|--|
| Patient's Last Name | | First | M.I. | Date of Birth / / | Age | Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk |
| Address | | City | State | Zip | County of Residence | |
| Phone Number | Patient ID Number | Ethnic Origin <input type="checkbox"/> His. <input type="checkbox"/> Non-His. | | Race <input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> A/PI <input type="checkbox"/> Am.Ind. <input type="checkbox"/> Other | | |
| DISEASE INFORMATION | | | | | | |
| Disease/Organism | | | Date of Onset / / | | Date of Diagnosis / / | |
| List Symptoms/Comments | | | | Highest Temperature | | |
| | | | | Days of Diarrhea | | |
| Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | Admission Date / / | Discharge Date / / | Died? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk | Date of Death / / | | |
| Hospital Name: | | | Is Patient Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # wks _____ | | | |
| School/Daycare Associated? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | Outbreak Associated? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Name of School/Daycare: | | | Food Handler? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Person or Agency Completing form: Name: | | | Attending Physician: Name: | | | |
| Address: | | | Address: | | | |
| Phone: | | Date of Report: / / | | Phone: | | |
| LABORATORY INFORMATION | | | | | | |
| Date | Name or Type of Test | Name of Laboratory | Specimen Source | Results | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| ADDITIONAL INFORMATION FOR SEXUALLY TRANSMITTED DISEASES ONLY | | | | | | |
| Method of case detection: <input type="checkbox"/> Prenatal <input type="checkbox"/> Community & Screening <input type="checkbox"/> Delivery <input type="checkbox"/> Instit. Screening <input type="checkbox"/> Reactor <input type="checkbox"/> Provider Report <input type="checkbox"/> Volunteer | | | | | | |
| Disease: <input type="checkbox"/> Syphilis | | Stage <input type="checkbox"/> Primary (lesion) <input type="checkbox"/> Secondary (symptoms) <input type="checkbox"/> Early Latent <input type="checkbox"/> Late Latent <input type="checkbox"/> Congenital <input type="checkbox"/> Other | Disease: <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Chancroid | Site: (Check all that apply) <input type="checkbox"/> Genital, uncomplicated <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Anorectal <input type="checkbox"/> Other _____ <input type="checkbox"/> Ophthalmic <input type="checkbox"/> PID/Acute Salpingitis | Resistance: <input type="checkbox"/> Penicillin <input type="checkbox"/> Tetracycline <input type="checkbox"/> Other _____ | |
| Date of spec. Collection | Laboratory Name | Type of Test | Results | Treatment Date | Medication | Dose |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| If syphilis, was previous treatment given for this infection? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| If yes, give approximate date and place _____ | | | | | | |

902 KAR 2:020 requires health professionals to report the following diseases to the local health departments serving the jurisdiction in which the patient resides or to the Kentucky Department for Public Health (KDPH).

(Copies of 902 KAR 2:020 available upon request)

REPORT IMMEDIATELY by TELEPHONE to the Local Health Department or the KY Department for Public Health:

- Unexpected pattern of cases, suspected cases or deaths which may indicate a newly recognized infectious agent
- An outbreak, epidemic, related public health hazard or act of bioterrorism, such as SMALLPOX

Kentucky Department for Public Health in Frankfort
Telephone 502-564-3418 or 1-888-9REPORT (973-7678)
FAX 502-696-3803

REPORT WITHIN 24 HOURS

| | | |
|-------------------------------------|-------------------------------|---|
| Anthrax | Encephalitis, West Nile | Rabies, animal |
| Botulism | <i>Haemophilus influenzae</i> | Rabies, human |
| Brucellosis | invasive disease | Rubella |
| Campylobacteriosis | Hansen's disease | Rubella syndrome, congenital |
| Cholera | Hantavirus infection | Salmonellosis |
| Cryptosporidiosis | Hepatitis A | Shigellosis |
| Diphtheria | Listeriosis | Syphilis, primary, secondary, early latent or congenital |
| <i>E. coli</i> O157:H7 | Measles | Tetanus |
| <i>E. coli</i> shiga toxin positive | Meningococcal infections | Tularemia |
| Encephalitis, California group | Pertussis | Typhoid Fever |
| Encephalitis, Eastern Equine | Plague | <i>Vibrio parahaemolyticus</i> |
| Encephalitis, St. Louis | Poliomyelitis | <i>Vibrio vulnificus</i> |
| Encephalitis, Venezuelan Equine | Psittacosis | Yellow Fever |
| Encephalitis, Western Equine | Q Fever | |

REPORT WITHIN ONE (1) BUSINESS DAY

| | | |
|----------------------------|-----------------------|----------------------|
| Foodborne outbreak | Hepatitis B, acute | Toxic Shock Syndrome |
| Hepatitis B infection in a | Mumps | Tuberculosis |
| pregnant woman or child | Streptococcal disease | Waterborne outbreak |
| born in or after 1992 | invasive, Group A | |

REPORT WITHIN FIVE (5) BUSINESS DAYS

| | | |
|------------------------------|--------------------------|-----------------------------------|
| ⚠ AIDS | ⚠ HIV infection | Rocky Mountain |
| Chancroid | Lead poisoning | spotted fever |
| <i>Chlamydia trachomatis</i> | Legionellosis | <i>Streptococcus pneumoniae</i> , |
| infection | Lyme disease | drug-resistant invasive |
| Ehrlichiosis | Lymphogranuloma venereum | disease |
| Gonorrhea | Malaria | Syphilis, other than primary, |
| Granuloma inguinale | Rabies, post exposure | secondary, early latent or |
| Hepatitis C, acute | prophylaxis | congenital |
| Histoplasmosis | | Toxoplasmosis |

Influenza virus isolates are to be reported weekly by laboratories.

902 KAR 02:065 requires long term care facilities to report an outbreak (2 or more cases) of influenza-like illnesses (ILI) within 24 hours to the local health department or the KDPH.

⚠ *All cases of HIV infections/AIDS are reportable to a separate surveillance system in accordance with KRS 211.180(1)b. To obtain report forms contact the HIV/AIDS Branch at (502)-564-6539.*

DO NOT REPORT ON THIS FORM.

Note: Animal bites shall be reported to local health departments within twelve (12) hours in accordance with KRS 258:065.

